# Brief of Amici Curiae NOW Legal Defense and Education Fund and 117 Organizations Committed to Women's Equality in Support of the Petitioners: *Rust v. Sullivan*

*A Note from the Editors:*

In 1970, Congress enacted Title X, which authorizes the Secretary of Health and Human Services to make grants to public and private organizations for the operation of family planning projects. According to one estimate, Title X projects provide services to an estimated 14.5 million women; of these women, nearly one third are adolescents, and 90% have incomes below 150% of the poverty line.

When Congress enacted Title X, it stipulated that no Title X funds "shall be used in programs where abortion is a method of family planning." While it is clear that the statute never permitted Title X funds to be used to subsidize or perform abortions, the government permitted Title X recipients to provide abortion counseling.

On February 2, 1988, the Secretary of Health and Human Services finalized regulations that reversed the prior policy of permitting the discussion of abortion. In addition to prohibiting employees in Title X-funded clinics from discussing abortions with clients, the new regulations require that recipients physically separate their Title X clinics from their activities that involve abortion counseling or advocacy.

The same day that the regulations were finalized, Dr. Irving Rust, the medical director of a Planned Parenthood center in the Bronx, filed suit in federal district court seeking to block implementation of the regulations. Dr. Rust claimed that the regulations violated the First and Fifth Amendments to the Constitution and the legislative intent of Title X. Dr. Rust was joined in his lawsuit by Planned Parenthood and other health care providers that receive Title X funds.

The district court upheld the regulations and held, among other things, that the prohibition on abortion counseling did not violate Dr. Rust's First Amendment rights. The Court of Appeals for the Second Circuit affirmed the district court, and the U.S. Supreme Court has agreed to hear the case.

Debevoise & Plimpton was chosen by NOW to write one of a limited number of amicus briefs to the Supreme Court. NOW asked the authors of the brief to focus primarily on the impact of these regulations on women, especially low-income women, teenagers, and women of color.

The *Yale Journal of Law and Feminism* signed on to NOW's amicus brief, and is now delighted to publish a brief of such critical importance to women.

IN THE

# Supreme Court of the United States

OCTOBER TERM, 1990

DR. IRVING RUST, on behalf of himself, his patients and all others similarly situated, DR. MELVIN PADAWER, on behalf of himself, his patients, and all others similarly situated, MEDICAL AND HEALTH RESEARCH ASSOCIATION OF NEW YORK CITY, INC., PLANNED PARENTHOOD OF NEW YORK CITY, INC., PLANNED PARENTHOOD OF WESTCHESTER/ROCKLAND, and HEALTH SERVICES OF HUDSON COUNTY, NEW JERSEY,

*Petitioners*,

v.

DR. LOUIS SULLIVAN, or his successor, Secretary of the United States Department of Health and Human Services,

*Respondents*.

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THE STATE OF NEW YORK, THE CITY OF NEW YORK, THE NEW YORK CITY HEALTH & HOSPITALS CORP.,

*Petitioners*,

v.

DR. LOUIS SULLIVAN, or his successor, Secretary of the United States Department of Health and Human Services,

*Respondents*.

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ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

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## BRIEF OF *AMICI CURIAE* NOW LEGAL DEFENSE AND EDUCATION FUND AND 117 ORGANIZATIONS COMMITTED TO WOMEN'S EQUALITY IN SUPPORT OF THE PETITIONERS

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***AMICI CURIAE***

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Action AIDS
All Peoples Congress
American Association of University Women
American Humanist Association
American Jewish Committee
Americans for Religious Liberty
Asian American Legal Defense and Education Fund
Association for Voluntary Surgical Contraception
Association for Women in Psychology
AWARE
Beverly Hills Bar Association
Black Women's Agenda, Inc.
Bradford County Coalition for Choice
Brooklyn Women's Political Caucus
California Women Lawyers
Canadian Abortion Rights Action League
Center for Law & Social Justice
Center for Public Representation
Colorado Women's Bar Association
Columbia-Greene Rape Crisis Center
Committee for Hispanic Children and Families
Committee to Defend Reproductive Rights
CHOICE
Disabled in Action in Metropolitan New York
Equal Rights Advocates, Inc.
Federation of Feminist Women's Health Centers
Feminist Institute
Hispanic Health Council
Human Rights Campaign Fund
Institute for Women's Policy Research
International Agency for Minority Artist Affairs
Jessie Smith Noyes Foundation
League of Women Voters of the United States
MADRE
Men of All Colors Together in New York
Mobilization for Youth Health Services, Inc.
Ms. Foundation For Women

My Sister's Place Washington D.C.
My Sister's Place New York
Nation Institute
National Abortion Rights Action League
National Association of Commissions for Women
National Center for Lesbian Rights
National Coalition Against Domestic Violence
National Council of Jewish Women
National Council for Research on Women
National Latina Health Organization
National Law Center on Homelessness and Poverty
National Lawyers Guild
National Medical Association
National Organization for Women
National Republican Coalition for Choice
National Woman Abuse Prevention Project
National Women's Health Network
National Women's Law Center
National Women's Political Caucus
New Directions for Women
New Jewish Agenda
New York Asian Women's Center
New York City Coalition for Women's Mental Health
New York Coalition of 100 Black Women
New York Pro-Choice Coalition
New York State Republican Family Committee
New York University Law Women
New York Women in Criminal Justice
Northwest Women's Law Center
Older Women's League
Organization for Obstetric, Gynecologic, and Neonatal Nurses
Pathfinder Fund
Pembroke Center for Teaching and Research on Women, Brown University
Project Choice: AIDS Education for Women of Color
Project on Women & Disability
Queen's Bench Bar Association of the San Francisco Bay Area
Racism & Homophobia in the Media Project
Radical Women
Rainbow Lobby, Inc.
Reproductive Health Services

San Francisco Women Lawyers Alliance
Santa Fe Health Education Project
Sex Information and Education Council of the United States
Southern California Women's Law Center
Students and Youth Against Racism
Students Organizing Students
Tucson Women's Commission
Union of American Hebrew Congregations
United Auto Workers District 65
Unitarian Universalist Association
Unitarian Universalist Women's Federation
United Church Board for Homeland Ministries
United Synagogue of America
VOICES in Action
Voters for Choice
Woman's Law Project
Women and AIDS Coalition
Women for Racial and Economic Equality
Women in Crisis Committee
Womenspace
Women USA
Women's Bar Association of Illinois
Women's Bar Association of Massachusetts
Women's Bar Association of the State of New York
Women's City Club of New York, Inc.
Women's Educational Center, Inc.
Women's Equal Rights Legal Defense and Educational Fund
Women's Health Action and Mobilization
Women's International Resource Exchange
Women's Legal Defense Fund
Women's Project
Women's Studies Program Hunter College, City University of New York
Women's Studies Program Smith College
Women's Studies Program Yale University
Workers World Party
Worldwatch
Yale Journal of Law and Feminism
YWCA of the USA
Zero Population Growth

## INTEREST OF *AMICI CURIAE*

This brief is filed on behalf of NOW Legal Defense and Education Fund and 117 organizations which share a common concern for the protection of women's rights, and in particular the fundamental right to reproductive autonomy, necessary to fulfill the Constitution's promises of liberty and equality for all. These organizations, representing millions of individual women and men from diverse backgrounds, have joined together to urge this Court to grant the relief sought by Petitioners and permanently enjoin the Title X regulations at issue. They believe the regulations profoundly impede exercise of the fundamental right to reproductive decision making essential to the health and the lives of the millions of low-income women who are served by federally funded family planning clinics. (Further statements of interest of *amici* are set forth at Appendix A.)

*Amici* have the consent of the parties to file this brief. Letters of consent have been filed separately with this Court.

## SUMMARY OF ARGUMENT

The Title X regulations at issue prohibit abortion counseling and require referral for prenatal care only, and thus impermissibly burden women's constitutionally protected right to reproductive decision making. That unconstitutional burden translates into concrete risks to the health and the lives of poor women—a disproportionate number of whom are young women and women of color—who are served by Title X clinics.

Under the guise of encouraging childbirth, the regulations prevent women seeking help at Title X clinics from receiving complete and unbiased medical advice about reproductive options. The ban on abortion information puts at risk the health and the lives of pregnant women, particularly those for whom complicating physical conditions make abortion a critical medical option. The regulations thus affirmatively interfere with a woman's constitutionally protected decision, informed by her physician, of whether or not to carry her pregnancy to term. The regulations also impermissibly infringe the basic first amendment right of the women served by Title X clinics to receive accurate reproductive health information from their health care providers. Finally, the regulations deprive women of equal protection under the law because they discriminate on the basis of gender and do so in a way that implicates a

woman's fundamental right to choose abortion and to receive information essential to informed reproductive health care.

The governmental purpose in enacting the regulations—to encourage child birth by curtailing access to information about abortion and abortion services—and the regulatory scheme devised to effect that purpose cannot survive strict scrutiny. The scheme cannot even stand as a rational means to achieve the government's purpose, given that the regulations both contravene the aim of Title X to promote public health and mandate violations of accepted medical practice.

*Amici* respectfully urge this Court to reject, as it has in the past, this blatant attempt to interfere with constitutionally protected reproductive decisions.

## ARGUMENT

### I. THE REGULATIONS UNDULY BURDEN A WOMAN'S FUNDAMENTAL PRIVACY RIGHT TO MAKE INFORMED REPRODUCTIVE DECISIONS FREE FROM UNWARRANTED GOVERNMENTAL INTERFERENCE.

The regulations prevent the women served by Title X clinics from freely and independently deciding whether or not to carry a pregnancy to term, as is their right under *Roe v. Wade*, 410 U.S. 113 (1973), and cases following *Roe*. By suppressing all mention of abortion while simultaneously compelling referral for prenatal care, the regulations impermissibly intrude into the physician-patient dialogue concerning reproductive options.[1] Through the funding mechanism, they create significant obstacles to the constitutionally protected right of women seeking health care at Title X clinics to decide, with the necessary information at their disposal, whether or not to carry pregnancies to term.

The Court has recognized that if the sphere of "liberty" guaranteed under the due process clauses of the fifth and fourteenth amendments is to "extend[] to women as well as to men," women must have the autonomy to decide whether and when to bear children, *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 772 (1986), and to be free from unwarranted governmental intrusion into "matters so fundamentally affecting a person as the decision whether to bear or beget a child," *Eisenstadt*

1. The regulation's ban on abortion counseling and referral affects not only women who are already pregnant, but also women using Title X family planning services for non-pregnancy related needs. *See infra* p. 35 and note 30.

*v. Baird*, 405 U.S. 438, 453 (1972); *See Hodgson v. Minnesota*, 58 U.S.L.W. 4957, 4961 (U.S. June 25, 1990) & 4968 (O'Connor, J., concurring); *Harris v. McRae*, 448 U.S. 297, 312-318 (1980); *Carey v. Population Services International*, 431 U.S. 678, 685, 687 (1977); *Roe v. Wade*, 410 U.S. 113, 152-53 (1973); *Griswold v. Connecticut*, 381 U.S. 479, 502-03 (1965) (White, J., concurring). Absent the right to decide whether or not to terminate a pregnancy, the freedom to make the child-bearing decision would be hollow.[2]

Recognizing that a woman needs medical advice to decide whether or not to continue a pregnancy, the Court has carefully protected the physician's role in the woman's decision making process. *See, e.g., City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 447 (1983). Because her decision is "inherently, and primarily, a medical decision," *Roe v. Wade*, 410 U.S. 113, 153 (1973), and "an important and often a stressful one," *Planned Parenthood of Missouri v. Danforth*, 428 U.S. 52, 67 (1976), it is "desirable and imperative that [the decision] be made with full knowledge of its nature and consequences," *Id.* Only by providing pregnant women with all the medical facts that bear upon the decision, can physicians assist women to make *informed* reproductive choices about one of the most important decisions in life.

For all women, pregnancy entails "profound physical, emotional and psychological consequences." *Michael M. v. Sonoma County Superior Court*, 450 U.S. 464, 471 (1981) (Rehnquist, J.). For many women, pregnancy, labor and delivery pose significant medical risks, particularly when cesarean sections account for one out of four deliveries. *See* D. Danforth, M. Hughey & A. Wagner, *The Complete Guide to Pregnancy* 228-31 (1983). The medical risks

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2. Because of advances in modern medicine, no bright line can be drawn between the decision to abort and the decision not to conceive. Both oral contraceptives and the intrauterine device operate after fertilization. *See* R. Hatcher, E. Guest, F. Stewart, J. Trussell, S. Bowen & W. Cates, *Contraceptive Technology* 252-53, 377 (14th rev. ed. 1988). Moreover, no method of birth control is 100 percent effective. *See* Jones & Forrest, *Contraceptive Failure Rates in the United States*, 21 Fam. Plan. Persp. 103 (1989). The failure rates for contraceptives used for a 1-year period are as follows: the Pill - 6.2%; the condom - 14.2%; the diaphragm - 15.6%; the rhythm method - 16.2%; and spermicides - 26.3%. *Id.* at 109. A study of women who had abortions in 1987 revealed that 51.3% had been using a contraceptive method during the month in which they became pregnant. Henshaw & Silverman, *The Characteristics and Prior Contraceptive Use of U.S. Abortion Patients*, 20 Fam. Plan. Persp. 158, 167 (1988).

Furthermore, because of the high risks of sexual violence, no woman of child-bearing capacity is safe from an unwanted pregnancy. *See* Federal Bureau of Investigation, *Uniform Crime Reports for the United States* 6, 13-15 (1987) (In 1987, one forcible rape every six minutes); N.Y. Times, Sept. 28, 1987, at B5, col. 1 (113,000 cases of child sexual abuse reported in 1985); S. Apeton, *Sexual Assault Among Adolescents* 130-34 (1983) (very high incidence of date rape among adolescents); D. Finklehor & K. Yllo, *License to Rape: Sexual Abuse of Wives* 6-8 (1985) (estimating 10-14% of all married women experience marital rape).

associated with carrying pregnancy to term should not be underestimated: of every ten women who experience pregnancy and childbirth, six are treated for some medical complication and three are treated for major complications. *See* R. Gold, A. Kenney & S. Singh, *Blessed Events and the Bottom Line: Financing Maternity Care in the United States* 10 (1987).

In comparison, legal abortion is safer than childbirth. Less than one percent of all abortion patients experience a major complication associated with the procedure. *See* The Alan Guttmacher Institute, *Abortion and Women's Health: A Turning Point for America?* 32 (1990). At eight weeks of gestation or earlier, the risk of death from abortion is about 20 times lower than that of childbirth; at no point during pregnancy is abortion more dangerous than childbirth. *See* LeBolt, Grimes & Cates, *Mortality from Abortion and Childbirth: Are the Populations Comparable?*, 248 J. Am. Med. A. 188, 191 (1982).

As the primary source of federal support for family planning and reproductive health services, funding over 3,900 clinics nationwide, Title X served 4.3 million low-income women in 1988, with a target population consisting of an estimated 14.5 million women at risk of unintended pregnancy, including 5 million adolescents between the ages of 15 and 19. Note, *The Title X Family Planning Gag Rule: Can the Government Buy Up Constitutional Rights?*, 41 Stan. L. Rev. 401, 408 (1989) (collecting sources). Thirty percent of these women are women of color, *see* The Alan Guttmacher Institute, *Organized Family Planning Services in the United States 1981-1983* 28, 30 (1984), and eighty percent have incomes below 150 percent of the poverty line, *see* Declaration of Dr. Stanley Henshaw, Deputy Director of Research, The Alan Guttmacher Institute, ¶ 18 (194JA).[3]

The right to make informed decisions concerning reproductive health care is particularly important for low-income women served by Title X. The communities in which they live suffer from disproportionately high rates of teenage pregnancy and a myriad of diseases (high blood pressure, hypertension, diabetes, cancer, sickle cell anemia and AIDS) that increase the risks associated with pregnancy.[4] Pregnant teenage women are twenty-four times more likely

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3. Citations to the Joint Appendix that accompanies the Petitioners' Briefs are made to the page number therein as "(__JA)." Citations to the appendix that accompanied the petitions are made to the page number therein as "(__a)." Citations to the Joint Appendix filed in the Second Circuit are made to the page number therein as "(__A)."

4. *See generally* M. Rudov & N. Santangelo, *Health Status of Minorities and Low-Income Groups* (1979). The AIDS epidemic has particularly severe consequences for these communities. A recent study predicts that by 1991, AIDS will become one of the five leading causes of death among women in the child-bearing years nationwide. Chu, Buehler & Berkelman, *Impact of Human Immunodeficiency Virus Epidemic Mortality in Women of Reproductive Age, United States*, 264 J. Am. Med. A. 225 (1990). The racial disparities uncovered by the study are dramatic: in 1988, AIDS killed nine times as many black

to die from childbirth than from a first trimester abortion. Carlson, *Abortion's Hardest Cases*, Time, July 9, 1990, at 22, 25. Black women, disproportionately represented in low-income communities,[5] are nearly three times more likely to die from complications of pregnancy or childbirth than are white women. U.S. Dep't of Health and Human Services, *Health: United States 1989*, at 33 (1990).

By prohibiting any mention of abortion, *see* 42 C.F.R. §§ 59.8(a)(1)-(4) (1989), the Title X regulations deprive low-income women of full health care counseling and information critical to their reproductive decision making and treatment. Section 59.8 of the regulations forbids practitioners in Title X clinics from informing their patients either of the availability of abortion or where abortion-related information can be obtained. 42 C.F.R. § 59.8(a)(1) (1989). Even when women request information about abortion, they may be told only that "the project does not consider abortion an appropriate method of family planning and therefore does not counsel or refer for abortion." 42 C.F.R. § 59.8(b)(5) (1989). Furthermore, the regulations do not simply censor abortion-related speech: they require that pregnant women be given a list of health care providers "that promote the welfare of mother and unborn child." 42 C.F.R. § 59.8(a)(2) (1989). This referral list must include all available prenatal care providers that do not perform abortions, and it cannot include any health care providers that offer abortion as their "principal business." 42 C.F.R. § 59.8(a)(3) (1989).

While the government may implement "a value judgment favoring childbirth over abortion . . . by the allocation of public funds," *Maher v. Roe*, 432 U.S. 464, 474 (1977), it cannot, absent a compelling justification, place "obstacle—absolute or otherwise—in the pregnant woman's path to an abortion." *Id.* By altering medical counseling through withholding information concerning abortion and prescribing information designed to cause women to carry to term, the regulations erect significant obstacles to women's reproductive decision making, hidden but nevertheless very real to the women served by Title X. The regulations' intrusion into the physician-patient dialogue impermissibly crosses the line between "state encouragement of an alternative

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women as white women. *Id.* at 226. AIDS is already the leading killer of black women of child-bearing years in New York and New Jersey. *Id.* at 227.

Pregnancy both accelerates the course of AIDS in a child-bearing woman and poses a 30-50% risk that her newborn baby will be HIV-infected. *See* Minkoff, *Care of Pregnant Women Infected With Human Immunodeficiency Virus*, 258 J. Am. Med. A. 2714 (1987).

5. In 1984, 32.3% of Black women and 26.4% of Hispanic women lived below the poverty level, as compared to 11.5% of white women. Wilson, "Women and Poverty: A Demographic Overview," in *Women, Health and Poverty* 26, (C. Perales & L. Young eds. 1988).

activity consonant with legislative policy" and "direct state interference with a protected activity." *Maher*, 432 U.S. at 475.

Unlike the selective subsidies of childbirth upheld in *Maher v. Roe*, 432 U.S. 464 (1977), and *Harris v. McRae*, 448 U.S. 297 (1980), and the selective allocation of public hospitals and staffs upheld in *Webster v. Reproductive Health Services*, 109 S. Ct. 3040, 3052-53 (1989), the Title X regulations seek to encourage childbirth by affirmatively impairing women's reproductive choice. *Maher* and *McRae* involved refusals to fund abortions,[6] not governmental schemes to interfere with a woman's decision making process by withholding information and providing misinformation. In *Reproductive Health Services v. Webster*, 851 F.2d 1071, 1080 (8th Cir. 1988) (en banc), the Eighth Circuit distinguished Missouri's ban on "encouraging or counseling" abortion from the restrictions in *Maher* and *McRae*, declaring that it could "perceive of few obstacles more burdensome to the right to decide than a state-imposed blackout on the information necessary to make a decision."[7] The Title X regulations present an *a fortiorari* case, for they not only impose a blackout, but they also compel Title X health care providers to transmit skewed information that will mislead Title X patients into carrying pregnancies to term.

The Title X regulations are an even more serious interference in the physician-patient dialogue than were the requirements struck down in *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 444 (1983), that compelled health care providers to disseminate information "designed to influence the woman's informed choice between abortion or childbirth."[8] The Title X regulations obstruct the decisionmaking process more

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6. In *Maher*, the Court observed that the statute at issue "imposed no restriction on access to abortions that was not already there." 432 U.S. at 474. Similarly, the Court noted in *McRae* that the funding restriction left an indigent woman "with at least the same range of choice in *deciding* whether to obtain a[n] . . . abortion as she would have had if Congress had chosen to subsidize no health care costs at all." 448 U.S. at 317. (emphasis added)

7. The Court did not address the constitutionality of Missouri's ban on counseling in *Webster v. Reproductive Health Services*, 109 S.Ct. 3040 (1989). The issue was dismissed as moot because the State interpreted the restriction as directed not at the conduct of any physician or health care provider, but only at those responsible for expending funds. *Id.* at 3053-3054.

8. In *Akron*, the Court held that by forcing physicians to furnish all their pregnant patients with an "inflexible list of information," the ordinance "unreasonably . . . placed 'obstacles in the path of the doctor upon whom [a woman is] entitled to rely for advice in connection with her decision.'" *Akron*, 462 U.S. at 444-445 (quoting *Whalen v. Roe*, 429 U.S. 589, 604 n.33 (1977)). The Court reasoned that "full vindication of the woman's fundamental right [to reproductive choice] necessarily requires that her physician be given 'the room he needs to make his best medical judgment.'" *Id.* at 427 (quoting *Doe v. Bolton*, 410 U.S. 179, 192 (1973)). That room includes the physician's discretion to provide her pregnant patient with information relevant to her particular needs, *Id.* at 443, when "both assisting the woman in the decisionmaking process and implementing her decision should she choose abortion," *Id.* at 427.

aggressively than did the Pennsylvania statute struck down in *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986) which required physicians to provide their pregnant patients with a description of fetal development and a list of agencies offering alternatives to abortion.[9]

Contrary to professional standards that require balanced counseling and discussion of the full range of options to which a woman is entitled when pregnancy is diagnosed, *see* American College of Obstetricians and Gynecologists, Statement of Policy: Further Ethical Considerations in Induced Abortion 2-3 (Dec. 1977),[10] the regulations require Title X health care providers to direct their counseling solely towards promoting childbirth. Health-related abortion restrictions that so "depart from accepted medical practice," *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. at 431 & 454 (O'Connor, J., dissenting), as these regulations do, unduly burden a woman's right to decide whether or not to continue a pregnancy.

By censoring information on abortion and compelling referral for prenatal care, section 59.8 of the regulations will lead many women to believe wrongly that abortion is not an available option. Some women, especially those who are uneducated or immigrants from countries where the right to abortion is restricted, may be prevented from discovering that abortion is legal in the United States.[11] Out of fear of incurring their doctor's disapproval or ex-

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9. The Court described these requirements as "an outright attempt to wedge Pennsylvania's message discouraging abortion into the privacy of the informed consent dialogue between the woman and her physician." *Thornburgh*, 476 U.S. at 762. The Court acknowledged that even standing alone the list of prenatal and neonatal care agencies could not pass constitutional muster:

> Even the listing of agencies . . . presents serious problems: it contains names of agencies that well may be out of step with the needs of the particular woman and thus places the physician in an awkward position and infringes upon his or her professional responsibilities. Forcing the physician or counselor to present the materials and the list to the woman makes him or her in effect an agent of the State in treating the woman and places his or her imprimatur upon both the materials and the list. All this is, or comes close to being, state medicine imposed upon the woman, not the professional medical guidance she seeks, and it officially structures -- as it obviously was intended to do -- the dialogue between the woman and her physician.

*Id.* at 762-63 (citation omitted).

10. *See also* American College of Obstetricians and Gynecologists, *Standards for Obstetric-Gynecologic Services* 57 (6th ed. 1985) ("In the event of an unwanted pregnancy, the physician should counsel the patient about her options of continuing the pregnancy to term and keeping the infant, continuing the pregnancy to term and offering the infant for legal adoption, or aborting the pregnancy.") For a fuller discussion of the ethical issues raised, see Briefs of *Amici Curiae* of the American Public Health Association, *et al.* and the American College of Obstetricians and Gynecologists, *et al.*

11. *See generally* C. Tietze & S. Henshaw, *Induced Abortion: A World Review* (6th ed. 1986). In fact, ignorance regarding the availability of abortion is pervasive throughout American society. *See* National Abortion Rights Action League, Hickman-Maslin Research Poll for American Viewpoint 4 (1987) (36% of American adults believe that abortion is available during the first three months of

posing themselves to prosecution, many women will be reluctant to break the silence on abortion and ask about it. The regulations deprive these women of the opportunity to decide whether or not to continue a pregnancy, for they will not even realize they have a choice to make.

Those women who know abortion is an option and ask about its availability must be told only that "the project does not consider abortion an appropriate method of family planning and therefore does not counsel or refer for abortion." 42 C.F.R. § 59.8(b)(5) (1989). Many women will understand this message to mean that they have no safe alternative to carrying their pregnancy to term and that abortion is not appropriate for them. Declaration of Dr. Irving Rust, Medical Director of the Bronx Center of Planned Parenthood, New York City, ¶ 15 (254JA).[12] If information on the health of their "unborn child" is the only guidance women receive, they may well feel compelled to carry to term or to turn to dangerous attempts to self-abort or even to suicide.[13] Teenage girls, who are often scared, ashamed and alone when faced with pregnancy, are particularly susceptible to suggestion from their physicians that abortion is not permissible or available. Declaration of Toni Morgan, ¶¶ 7-8 (219-220 JA).

Even the women who resist the government's censorship attempts, identify abortion as a safe and legal option, and choose to obtain abortions are harmed by the increased health risks and costs caused by the delay the regulations impose on their process of obtaining appropriate health care. *See Massachusetts v. Secretary of Health & Human Services*, 899 F.2d 53, 69-70 (1st Cir. 1990) (en banc). Under the regulations, women who enter Title X facilities with false, but not unreasonable, expectations of balanced counseling will be referred only to prenatal clinics—even if they express their desire to terminate their pregnancy. Though there may be some abortion providers on the list of prenatal care providers given them, women will not be able to identify the abortion providers except by a series of telephone calls or hit or miss visits to several facilities. This is particularly onerous for low-income women who often lack access to a car, the fare for other transportation or even a telephone.[14] Combined with scheduling difficulties, work and child care commitments, school and transportation problems, this circuitous path to abortion may entail

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pregnancy only under "extreme circumstances" or is "not allowed").

12. Even if women are unsure of the meaning of this message, few will ask their doctors for fuller explanation because all patients are conditioned to "follow doctors' orders" unquestioningly. Katz, *Physician-Patient Encounters "On a Darkling Plain"*, 9 W. New Eng. L. Rev. 207, 215 (1987)

13. Declaration of Dr. Irving Rust ¶¶ 11 (252JA), 14-16 (253-54JA).

14. *See* Nsiah-Jefferson, "Reproductive Laws, Women of Color and Low-Income Women," in *Reproductive Laws for the 1990s* 24 (N. Taub & S. Cohen eds. 1988).

delays of days, weeks or even months. Such delays may well push women into the second trimester of pregnancy, significantly increasing the health risks for those women who choose abortions.[15] For the thousands of teenagers whose denial, fear, shame and uncertainty often result in a late initial visit to the clinic,[16] further delay resulting from the regulations can be critical.

In addition to increasing health risks, delay makes abortion more costly[17] and difficult to obtain.[18] This is especially true for low-income women living in rural areas where abortion providers are scarce and women often have to travel to another county or even another state to obtain an abortion.[19] Because most of the women served by Title X do not have access to alternative health care,[20] many will learn of affordable abortion clinics only through word of

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15. The Court recently acknowledged that an abortion delay of 48 hours to a week or more "increased the medical risk associated with the abortion procedure to 'a statistically significant degree.'" *Hodgson v. Minnesota*, 58 U.S.L.W. 4957, 4963 (U.S. June 25, 1990) (accepting the finding of the District Court). With each passing week in the second trimester, the risks of major complications from even a legal abortion increase by approximately 30 percent and the mortality risk by 50 percent. Declaration of Dr. George Morley ¶ 12, President of the American College of Obstetricians and Gynecologists, (227JA).

16. *See Hodgson v. Minnesota*, 58 U.S.L.W. at 4970 (Marshall, J., concurring in part and dissenting in part) (citing 1 National Research Council, *Risking the Future: Adolescent Sexuality, Pregnancy and Childbearing* 114 (C. Hayes, ed. 1987)).

17. The cost of an abortion increases as pregnancy advances. Clinics charge an average of $231 for an abortion at 8 weeks; $400 at 16 weeks and $700 at 20 weeks. The Alan Guttmacher Institute, *Abortion and Women's Health: A Turning Point for America?* 26 (1990). The Court invalidated second trimester hospitalization requirement in *Akron* because it imposed "a heavy, and unnecessary, burden," more than doubling the cost of "women's access to a relatively inexpensive, otherwise accessible, and safe abortion procedure." 462 U.S. at 438.

18. Only 17% of all abortion providers perform abortions after the 16th week of pregnancy. Henshaw, Forrest, & Van Voort, *Abortion Services in the United States, 1984 and 1985*, 19 Fam. Plan. Persp. 63, 69 (1987).

19. In 1985, 82% of all U.S. counties lacked an abortion provider, yet these counties were home to 30% of all women of childbearing years. *See* Henshaw, Forrest, & Van Voort, *supra* n.18, at 65. The difficulty in locating an abortion provider is increasing as fewer doctors are willing to perform abortions for fear of harassment. N.Y. Times, Jan. 8, 1990, at A1, col. 1. South Dakota and North Dakota now only have one abortion provider each and in Wyoming, more than 50% of women go out of state to obtain an abortion. N.Y. Times, June 28, 1990, at A10, col. 5.

20. Even HHS has acknowledged that "[f]or many clients, family planning clinics are their *only* continuing source of health information and medical care." U.S. Dep't of Health and Human Services, *Program Guidelines for Project Grants for Family Planning Services* § 9.4 (1981) (emphasis added). Few women served by Title X have any health insurance which would enable them to afford private care. Of all women aged 18-24, almost 30% have no insurance coverage. Tallon & Block, "Changing Patterns of Health Insurance Coverage; Special Concerns for Women," in *Women, Health and Poverty* 119, 122 (C. Perales & L. Young eds. 1988). Of all women aged 15-44 living below the poverty level, 36% are uninsured. *Id.* The rates are worse for women of color: 21.8% of Blacks and 29.1% of Hispanics are uninsured, compared with 14% of whites. Nsiah-Jefferson, "Reproductive Laws, Women of Color, and Low-Income Women," in *Reproductive Laws for the 1990s* 17, 27 n.46. (N. Taub & S. Cohen eds. 1988). Moreover, "uninsured minorities obtain less physician care and less hospital care, and travel further and wait longer for care, than white uninsured." Dallek, *Health Care for America's*

mouth. In their desperate and frustrated quest to end an unwanted pregnancy some women will find and turn to illegal abortionists.[21] For these women, delay may spell death.[22]

The regulations will have perhaps their cruelest effect on those low-income women who have serious complicating conditions, such as hypertension, eclampsia, diabetes, congenital heart disease, cancer, sickle-cell anemia, kidney disease and certain respiratory, urinary and neuromuscular disorders. Continuation of pregnancy for women suffering from these diseases carries grave risks for the health of both the mother and the fetus.[23] While the regulations at issue will permit professionals in Title X clinics to disclose the existence of complicating conditions to their patients, they will prevent counseling of abortion as an alternative to carrying a pregnancy to term.[24] As a result, women with serious complicating conditions will not learn that their pregnancies pose substantial health risks that may require an abortion to preserve their health or save their life. In addition, the regulations' mandated referral to prenatal care will reinforce the false impression that the pregnancy does not actually threaten their health.

As a result of the Title X regulations' enforced misinformation, low-income women who have restricted access to affordable, comprehensive reproductive health care and counseling will be impermissibly coerced to make uninformed, and often dangerous, reproductive decisions. For this reason, the

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*Poor: Separate and Unequal*, 20 Clearinghouse Rev. 361, 370 (1986).

21. Recently, Becky Bell, an Indiana high school student, died of a massive infection after she sought an illegal abortion to avoid disappointing her parents by telling them she was pregnant. Carlson, *Abortion's Hardest Cases*, Time, July 9, 1990, at 22.

22. *See Hodgson v. Minnesota*, 58 U.S.L.W. 4957, 4970 (U.S. June 25, 1990) (Marshall, J., concurring in part and dissenting in part) (citing Greydanus & Railsback, *Abortion in Adolescence*, 1 Seminars in Adolescent Med. 213, 214 (1985) (mortality rate 100 times greater from illegal abortion than legal one)).

23. For example, diabetes poses serious risks during pregnancy. Pregnancy-induced diabetes occurs in approximately one to three percent of pregnancies. *Medical Complications During Pregnancy* 41 (G. Burrow & T. Ferris 3d ed. 1988). In addition, approximately 1.5 million women of childbearing age are known to have diabetes. *Maternal-Fetal Medicine* 925 (R. Creasey & R. Resnik 2d ed. 1989). A pregnant woman with diabetes is four times as likely to develop hypertensive disease; she is also more likely to develop infections of a greater severity, injure her birth canal during vaginal delivery, require a caesarian section, and hemorrhage after delivery. *Williams Obstetrics* 600 (J. Pritchard, P. MacDonald & N. Grant 17th ed. 1985). *See* Brief of *Amici Curiae* of the American College of Obstetricians and Gynecologists, *et al.* for a full discussion of the health risks of pregnancy to women with complicating medical conditions.

24. *See* Declaration of Dr. George Morley, President of the American College of Obstetricians and Gynecologists, ¶ 17 (228-29JA); Declaration of Prof. Howard Minkoff, Professor of Obstetrics and Gynecology, State of New York Health Science Center, ¶ 8 (648A); Declaration of Dr. Allan Rosenfield, Professor of Obstetrics-Gynecology and Public Health, Columbia University School of Public Health, ¶ 22 (83a).

Title X regulations do more than encourage childbirth over abortion: they actively interfere with a woman's ability to decide whether to carry a pregnancy to term.

## II. THE REGULATIONS VIOLATE THE FIRST AMENDMENT RIGHTS OF LOW-INCOME WOMEN TO RECEIVE INFORMATION FROM HEALTH CARE PROVIDERS PRACTICING AT TITLE X CLINICS.

The regulations hold the first amendment rights of women and their health care providers hostage to a funding scheme requiring the dissemination of inaccurate and distorted information. Through these funding restrictions, the government has impaired the first amendment right of women to receive information about their reproductive health.

It is now well established that the first amendment protects the listener's right to receive information. *Virginia Board of Pharmacy v. Virginia Citizens Consumer Council*, 425 U.S. 748, 756-57 (1975); *Kleindienst v. Mandel*, 408 U.S. 753, 762-63 (1972); *Griswold v. Connecticut*, 381 U.S. 479, 482 (1965). As early as its decision in *Meyer v. Nebraska*, 262 U.S. 390 (1923), the Court clarified that, in addition to protecting the freedom to speak, the Constitution safeguards "opportunities . . . to acquire knowledge." *Id.* at 482. In keeping with this principle, the Court has struck down a wide variety of government restrictions that offended the "(f)irst amendment right to receive information and ideas." *Kleindienst v. Mandel*, 408 U.S. 753, 762 (1972) (quoting *Stanley v. Georgia*, 394 U.S. 557, 564 (1969)). *See, e.g., Globe Newspaper Co. v. Superior Court*, 457 U.S. 596 (1982); *Richmond Newspapers, Inc. v. Virginia*, 448 U.S. 555 (1980); *Procunier v. Martinez*, 416 U.S. 396, 408-09 (1974); *Lamont v. Postmaster General*, 381 U.S. 301, 306-07 (1957); *Thomas v. Collins*, 323 U.S. 516, 534 (1945).[25] The reciprocal nature of the right to receive information derives from the fact that it "is a necessary predicate to the *recipient's* meaningful exercise of his own right of speech, press and political freedom." *Board of Education v. Pico*, 457 U.S. 853, 867 (1982) (plurality opinion) (emphasis in original).[26]

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25. In these cases, the Court has held unconstitutional government attempts to stem the flow of information in public schools, courts of law, prisons and the mails. The regulations' efforts to suppress vital medical communications in Title X clinics are surely more reprehensible, given that this "blackout" not only curtails the sharing of ideas and information critical to our polity but also directly undermines the health and lives of millions of women.

26. Justice Brennan stated that the listener's right to receive information warrants first amendment protection because "the dissemination of ideas can accomplish nothing if otherwise willing addressees are not free to receive and consider them. It would be a barren marketplace of ideas that had only sellers

In this instance, the right to receive information is a necessary predicate to the constitutionally protected right to reproductive decision making. As the Court declared in *Griswold*, the very first case recognizing the protected nature of the relationship between a patient seeking family planning information and her physician, "[t]he right of freedom of speech and press includes not only the right to utter or print, but the . . . right to receive . . . [information]." 381 U.S. at 482.[27]

Despite the fact that the first amendment "prohibit(s) [the] government from limiting the stock of information from which members of the public may draw," *First National Bank of Boston v. Bellotti*, 435 U.S. at 765, 783, *reh'g denied*, 438 U.S. 907 (1978),[28] the regulations withdraw abortion counseling and referrals in the context of low-income health care from the stock of information that millions of women can receive and casts prenatal care and childbirth as the only option.[29] Therefore, the Second Circuit's conclusion that the regulations were not viewpoint-based, because they limited both "pro and con" advocacy about abortion, *New York v. Sullivan*, 889 F.2d 401, 414 (2d Cir. 1989), ignored the regulations' obvious intent actively to interfere with a woman's decision whether or not to carry her pregnancy to term. As the First Circuit correctly observed,

> It is naive to assert that not talking about abortion to a pregnant woman when discussing her options is value neutral. . . . By discussing only what is best for the unborn child, the counselor has already made the woman's choice. The Government, in restricting the counselor's options to that choice, enforces its choice.

*Massachusetts v. Secretary of Health and Human Services*, 899 F.2d 53, 72 (1st Cir. 1990) (en banc).[30] By prohibiting a woman from receiving abortion-related information, the regulations violate the Court's admonition, in another

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and no buyers." *Lamont*, 381 U.S. at 308 (Brennan, J., concurring).

27. Justice White has written that "[t]he self-expression of the communicator is not the only value encompassed by the First Amendment. One of its functions, often referred to as the right to hear or receive information, is to protect the interchange of ideas. Any communication of ideas . . . furthers the purposes of the first amendment." *First National Bank of Boston v. Bellotti*, 435 U.S. 765, 806, *reh'g denied*, 438 U.S. 907 (1978) (White, J., dissenting).

28. *See also Griswold*, 381 U.S. at 482 (the government "may not, consistently with the spirit of the First Amendment, contract the spectrum of available knowledge").

29. Note, *The Title X Family Planning Gag Rule: Can the Government Buy Up Constitutional Rights?* 41 Stan. L. Rev. 401, 402 (1989).

30. For a fuller discussion of the regulations' unconstitutional discrimination on the basis of viewpoint in a public forum, *see* Brief of *Amici Curiae* the Commonwealth of Massachusetts, *et al.*

first amendment context, that "[i]f there be time to expose through discussion the falsehood and fallacies . . . the remedy to be applied is more speech, not enforced silence." *Linmark Assoc. v. Willingboro*, 431 U.S. 85, 97 (1977) (quoting *Whitney v. California*, 274 U.S. 357, 377 (1927) (Brandeis, J., concurring)).

Protecting the dissemination of full and accurate medical information from governmental interference is vital. Such information is critical and is already of limited supply, especially to low-income women.[31] The pervasive nature of government regulation of medicine designed to protect the public through ensuring the quality of medical counseling, demonstrates the crucial importance of complete and accurate medical information to our society.[32] All states require that a license be obtained before a doctor can practice medicine and licensing is contingent upon completion of extensive education and training.[33] In addition, many doctors choose to develop specializations which restrict the availability of specific medical information even further, to a limited few in a given field.[34] While such efforts are intended to improve the quality of medical counseling, they also impose costs that necessarily restrict its availability.[35]

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31. Numerous studies and reports have noted increasing deterioration in access to health care services for low-income groups. *See, e.g.*, L.A. Times, July 17, 1990, at A1, col. 5. (noting that the United States infant mortality rate -- a prime indicator of the nation's health care access -- exceeds 10 per 1,000, placing the United States no better than 20th out of 22 industrial nations in a United Nations survey); Hatlie, *Professional Liability: The Case for Federal Reform*, 263 J. Am. Med. A. 586 (1990) (reporting increased diminution in the availability of health care in the United States and noting that "access problems are most pronounced in the maternal health field").

32. Public health and the practice of medicine are highly regulated by both the state and federal government, including the licensing of health care providers, facility construction, antitrust matters and environmental protection and the development and distribution of drugs. *See generally Health Care Sourcebook, A Compendium of Federal Laws, Regulations and Documents Relating to Health Law*, vols. 1 & 2 (W. Miller ed. 1989).

33. G. Annas, *The Rights of Patients* 252 (2d ed. 1989). Typically, a doctor is required to complete four years of undergraduate education, four years of medical school and four years of clinical education as a resident.

34. If a doctor chooses to specialize in a particular area of medicine, two or more years of additional training are necessary, and certification by a specialty board is required by most institutions. AMA Council on Medical Education, *Future Directions for Medical Education*, 248 J. Am. Med. A. 3225 (1982). *See also* AMA Council on Long Range Planning and Development, *The Future of General Internal Medicine*, 262 J. Am. Med. A. 2119 (1989) (number of primary health care specialists declining rapidly as more doctors are choosing specialization over becoming a general internist, because of higher pay and status).

35. The government's control over the practice of medicine also extends to the criminalization of the unauthorized practice of medicine. *See, e.g., Pinkus v. MacMahon*, 129 N.J. 367, 29 A.2d 885 (N.J. Sup. Ct. 1943) (owner of a food store engaged in authorized practice of medicine when he diagnosed shoppers' illnesses, prescribed a healthful diet and sold certain vitamins which he claimed had a curative effect); *New York v. Varas*, 110 A.D.2d 646 (2d Dept. 1985) (engaged in unauthorized

Over the past twenty years, the federal government has encouraged low-income women and the health facilities in their communities to rely on Title X to support affordable, quality reproductive health care, including abortion counseling and referral. To a large extent, Title X funding has displaced state and local government aid and private funding[36]. Thus, by preventing Title X health care workers from providing their patients with comprehensive and accurate health information about the option of abortion—despite its importance and limited availability—the government effectively places it beyond the reach of most, if not all, Title X patients. For Title X patients, medical advice about the "denied idea" of the option of abortion is not "*readily available* from the *same source* in other *accessible* locations," *Board of Education v. Pico*, 457 U.S. 853, 913 (1982) (Rehnquist, J., dissenting), and will be effectively foreclosed by the federal government.

Enhanced and improved medical information through government regulation is not the only factor defining the health care culture in the United States. The governing principles of medical ethics nationwide require that physicians communicate to the patient full information about her medical condition and treatment alternatives to ensure that the patient participates meaningfully in her treatment decisions.[37] This is premised on the view that such an approach results in the best medical decisions.

It is unreasonable, in the context of this medical culture to expect a woman who uses a Title X clinic to anticipate the forfeiture of full health care counseling and her own informed decision making when she walks through the Title X clinic doors. Indeed, one of the many apparent dangers of the regulations is that women entering Title X clinics are not warned that they are about to receive distorted, misleading information unrelated to their individual health needs. Moreover, even if formal warning notices were somehow provided to Title X patients, it would be unreasonable to expect that a Title X patient, or any patient, would meaningfully alter her expectation of the physician-patient relationship to accommodate any disclaimer stating that the clinic cannot mention abortion.[38]

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practice of medicine where the defendant never obtained a license to practice and conducted medical examinations, wrote prescriptions and provided diagnoses).

36. Approximately fifty percent of Title X projects' funding comes from federal sources, with the remaining ten percent generated by Medicaid and sliding scale fee payments. *See Massachusetts v. Secretary of Health and Human Services*, 899 F.2d 53, 55-56 (1st Cir. 1990) (en banc).

37. *See, e.g.*, American Medical Association, *Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association* ¶ 8.07, at 31-32 (1989); *Centerbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir.), *cert. denied*, 409 U.S. 164 (1972).

38. The element of trust and full reliance is crucial within the context of a physician-patient relationship. "The average patient has little or no understanding of the medical arts, and ordinarily has

The dangers of the government's censorship campaign become readily apparent when one hypothesizes a situation where the government enacts a regulation prohibiting oncologists in federally funded hospitals from counseling cancer patients about the treatment option of chemotherapy, while mandating referrals to facilities which primarily practice holistic medicine. Patients suffering from cancer would either be left unaware of the existence of chemotherapy, or be given the misleading message that chemotherapy was not a medically acceptable treatment option for many forms of cancer—in either case unable to make a fully informed treatment decision.

Thus, the government's censorship of abortion information infringes the most basic first amendment rights of patients of Title X facilities and ignores the Court's admonition that "people will perceive their own best interests only if they are well informed . . . the best means to that end is to open the channels of communication rather than to close them." *Virginia Pharmacy Board v. Virginia Consumer Council*, 425 U.S. 748, 770 (1975).

## III. THE REGULATIONS DEPRIVE WOMEN OF EQUAL PROTECTION UNDER THE LAW BECAUSE THEY DISCRIMINATE ON THE BASIS OF GENDER AND UNDULY BURDEN A WOMAN'S FUNDAMENTAL RIGHTS.

The regulations contravene the fourteenth amendment's prohibition on discrimination because they exclusively harm women. As a result of the regulations, women are denied important medical information necessary to make an informed decision about contraception or, if pregnant, about whether to continue a pregnancy. For example, a woman suffering from severe hypertension should be advised by her Title X physician both that the use of oral contraceptives is contraindicated and that pregnancy may threaten her life. The Title X physician would be precluded from fully informing her patient that barrier methods of contraception, with early abortion as a backup if the barrier

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only [her] physician to whom [she] can look for enlightenment with which to reach an intelligent decision." *Canterbury v. Spence*, 464 F.2d 772, 780, *cert. denied*, 409 U.S. 1064 (1972) (D.C. Cir. 1972). Thus a patient relies on her doctor for the accurate, complete and unbiased information she needs to make decisions about her health. *See* Affidavit of Dr. Jay Katz, Professor of Law and Psychoanalysis, Yale University, ¶¶ 7-8 (207JA):

> The doctor-patient relationship is based on trust . . . it is recognized by law as a fiduciary relationship. Because patients must be able to rely on their physicians to act in good faith and in their best interest, principles of law and ethics require them to do so.
>
> The physician thus has an obligation to be truthful, to respect the rights of the patient, and to disclose to the patient all pertinent facts regarding the patient's condition and treatment options including the risks and benefits of each.

method fails, are the safest type of contraception.[39]

Women, pregnant and non-pregnant, are the only people directly burdened by the Title X regulations.[40] Moreover, this gender-based burden curtails women's fundamental constitutional rights: a woman's fundamental privacy right to terminate a pregnancy and her first amendment right to receive information.[41]

The Court has held that measures classifying on the basis of gender are unconstitutional unless the party supporting the measure can "carry the burden of showing an 'exceedingly persuasive justification' for the classification." *Mississippi University for Women v. Hogan*, 458 U.S. 718, 724 (1982) (quoting *Kirchberg v. Feenstra*, 450 U.S. 455, 461 (1981)). *See also Craig v. Boren*, 429 U.S. 190, 197-199 (1976). Classifications based on gender have long been subjected to searching analysis because of the substantial burdens suffered by women when gender stereotypes are imposed on them. *See Mississippi University for Women*, 458 U.S. at 726; *Califano v. Goldfarb*, 430 U.S. 199, 211 (1977) (plurality opinion); *Stanton v. Stanton*, 421 U.S. 7, 14 (1975); *Frontiero v. Richardson*, 411 U.S. 677, 684 (1973) (plurality opinion). The Title X regulations impair a woman's constitutionally guaranteed liberty and autonomy by the pernicious strategy of keeping all necessary information from her. This

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39. *See* Tietze, Bongaarts & Schearer, *Mortality Associated with the Control of Fertility*, 8 Fam. Plan. Persp. 6 (1976); The Alan Guttmacher Institute, *Making Choices—Evaluating the Health Risks and Benefits of Birth Control Methods* (1983). The Food and Drug Administration requires manufacturers of intrauterine devices ("I.U.D.'s") to inform physicians that if a woman becomes pregnant with an I.U.D. in place, and removal is difficult, "termination of the pregnancy should be considered and offered the patient as an option . . ." 21 C.F.R. § 310.502(b)(1) (1989). Similarly, a woman who becomes pregnant while using oral contraceptives, "should be apprised of the potential risks to the fetus: the advisability of continuing the pregnancy in light of these risks should be discussed." K. Fineberg, J. Peters, J. Willson & D. Kroll, *Obstetrics/Gynecology and the Law*, 311 (1984).

40. Because this case involves placing affirmative burdens on all women's constitutional rights, *Geduldig v. Aiello*, 417 U.S. 484 (1974), is not controlling. *Geduldig* sustained the constitutionality of a state disability insurance program that excluded from coverage certain disabilities resulting from pregnancy because the group discriminated against included only pregnant women and not all women.

The program upheld in *Geduldig* is also distinguishable from the regulations at issue because it refused to extend to women a benefit that men could not receive. The Court has established a distinction between "merely refus[ing] to extend to women a benefit that men cannot and do not receive," and "impos[ing] on women a substantial burden that men need not suffer." *Nashville Gas Co. v. Satty*, 434 U.S. 136, 142 (1977) (deeming exclusion of pregnant employees sex discrimination under Title VII). Thus, even where a law places affirmative burdens on pregnant women alone, *Geduldig* has no force. *See also* Estrich and Sullivan, *Abortion Politics: Writing for an Audience of One*, 138 U. Penn. L. Rev. 119, 124 n.10 (1989).

41. Since the regulations discriminate against women in a way that infringes upon their fundamental rights, the regulations violate the equal protection clause and must be subjected to strict scrutiny. *See infra* at p. 25 and note 49.

strategy of misinformation, justified by the goal of "promoting childbirth,"[42] effectively reinvents the outmoded and dangerous notion that a woman's proper function is reproduction.[43] The Court has consistently struck down legislation that perpetuates "fixed notions concerning the roles and abilities of males and females," *Mississippi University for Women*, 458 U.S. at 726, even when their impact has been far less onerous than the effects of these regulations.[44]

Not only do the regulations impermissibly perpetuate stereotypes about a woman's proper role in society, they also deprive women of equal treatment with respect to the exercise of their fundamental right to privacy. All persons possess a right to privacy protecting certain personal decisions regarding marriage and family life from unwarranted governmental interference.[45] For a woman, this right includes the right to decide whether or not to terminate a pregnancy, with the chance to determine what is best for her given her physical,[46] emotional, economic, educational and family circumstances. In fact, this Court has recognized a woman's right to choose an abortion by striking down a regulation that would have required spousal consent because

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42. If the regulations are allowed to stand, a day may come when the government decides to impose burdens on men as well in the interest of "promoting childbirth." For example, the government may decide to mislead men, or withhold information altogether, about contraception so that a sexually active man might father more children.

43. Women have long been perceived as persons whose "paramount destiny and mission . . . [is] to fulfill the noble and benign office of wife and mother." *Bradwell v. Illinois*, 16 Wall. 130, 142 (1873) (Bradwell, J., concurring). People who would restrict women's access to abortion echo the views of Justice Bradley and believe that the only appropriate roles for women are those of mother and housewife. *See* Estrich & Sullivan *supra* note 40, at 152-53.

44. The Court has struck down: sex-based distinctions determining eligibility for survivors benefits under the Social Security Act, *Califano v. Goldfarb*, 430 U.S. 199 (1977); sex-based admission requirements for enrollments in nursing school, *Mississippi University for Women v. Hogan*, 458 U.S. 718 (1982); sex-based regulations determining quarters and medical allowances, *Frontiero v. Richardson*, 411 U.S. 677 (1973); sex-based regulations establishing different drinking ages for men and women, *Craig v. Boren*, 429 U.S. 190 (1976); and sex-based regulations determining government benefits, *Weinberger v. Weisenfeld*, 420 U.S. 636 (1975). None of these regulations actually interfered with a woman's constitutional rights much less jeopardized her health or life.

45. The freedom of personal choice implicit in the concept of constitutional liberty places beyond the intrusive reach of the government the decision to marry, *Loving v. Virginia*, 388 U.S. 1 (1967); the decision of when and whether to bear children, *see Griswold v. Connecticut*, 381 U.S. 479 (1965); and decisions regarding childrearing and education, *see Pierce v. Society of Sisters*, 268 U.S. 510 (1925); *Meyer v. Nebraska*, 262 U.S. 390 (1923). The freedom to choose the structure of one's family is deeply rooted in this Nation's history and tradition." *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977).

46. Over the nine months of pregnancy, a woman's uterus increases 500 to 1,000 times in size, displacing other bodily organs including the heart, appendix and gastrointestinal tract; her resting pulse rate quickens by ten to fifteen beats per minute and her heart may increase slightly in size; and her body weight increases by an average of twenty-five pounds. Even a healthy pregnant woman may experience nausea, vomiting, more frequent urination, back pain, fatigue, insomnia, labored breathing and water retention. *See Williams Obstetrics* 540-42 (P. MacDonald, J. Pritchard & N. Grant 17th ed. 1985).

"it is the woman who physically bears the child and who is the more directly and immediately affected by the pregnancy. . . ." *Planned Parenthood of Missouri v. Danforth*, 428 U.S. 52, 71 (1976).

No regulation in the Title X context infringes on men's privacy rights in a way that is comparable to the regulations' ban of any information about abortion to women.[47] Similarly, men face no obstacles to their first amendment right to receive medical information critical to decisions regarding their bodies or health. The regulations create two categories of doctor-patient relationships, one which presumptively allows men to receive full medical information and the other which deprives only women from obtaining complete and accurate information about their health.[48] This type of governmental discrimination clearly violates the equal protection clause.

## IV. THE TITLE X REGULATIONS AT ISSUE HERE CANNOT SURVIVE STRICT SCRUTINY BECAUSE THE GOVERNMENT LACKS A COMPELLING INTEREST AND THE REGULATIONS ARE NOT NARROWLY TAILORED TO SERVE ANY INTEREST.

The Title X regulations directly interfere with fundamental privacy and first amendment rights of women. Moreover, because the regulations exclusively harm women by burdening their fundamental rights, they also deprive women of equal protection under the law. The Title X regulations cannot survive strict scrutiny because the government can assert no "compelling interest" to justify the burdens placed on women's privacy and first amendment rights by the regulations, or their denial of equal protection.

In order to safeguard the individual against the invasive power of government, the Court turns its most "searching judicial inquiry" to governmental regulation that intrudes on the fundamental rights of its citizens. *City of Richmond v. J.A. Croson Co.*, 109 S. Ct. 706, 721 (1989). Thus, the Court has consistently applied strict scrutiny whenever a woman's privacy right to choose abortion is encumbered by substantial burdens. *See Hodgson v.*

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47. Recipients of Title X funds provide family planning services to both men and women. Services for men can include sterilization, sexually transmitted disease screening and treatment, condom distribution and general information. *See* Danielson & McNally, *Title X and Family Planning Services for Men*, 20 Fam. Plan. Persp. 234 (1988).

48. This is not a case of disproportionate impact but of exclusive impact because women are the only ones who are affected by the Title X regulations. In *Personnel Administrator v. Feeney*, 442 U.S. 256 (1979), by contrast, the veterans' preference upheld by this Court disadvantaged a class comprised of both men and women although the classification disproportionately disadvantaged women. The class affected by the regulations at issue is defined by a biological correlate of gender unlike *Feeney* where the class granted veterans' benefits also consisted of women.

*Minnesota*, 58 U.S.L.W. 4957, 4969 (U.S. June 25, 1990) (Marshall, J., concurring); *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986); *City of Akron v. Akron Center for Reproductive Health Inc.*, 462 U.S. 416 (1983); *Roe v. Wade*, 410 U.S. 113 (1973). The Court has also consistently applied strict scrutiny whenever the government intrudes on the first amendment right to receive information. *Griswold v. Connecticut*, 381 U.S. at 482.[49] In addition, strict scrutiny applies whenever legislation places burdens on a fundamental right in violation of the equal protection clause. *Zablocki v. Redhail*, 434 U.S. 374 (1978); *Skinner v. Oklahoma*, 316 U.S. 535 (1942).

The central purpose of this "searching judicial inquiry," *Croson*, 109 S. Ct. at 721, into governmental actions that infringe upon constitutionally protected rights and groups is to ensure that such actions serve a stated goal or interest of sufficient importance to justify infringement *and* that the means chosen to effect the goal are closely tailored to serve only the state interest with minimum intrusion upon the individual's protected rights. The regulations at issue here fail in both respects.

First, the overriding governmental purpose for Title X is to promote public health through the provision of family planning services for low-income clients[50]—a compelling interest. The regulations at issue here also serve the ancillary purpose of encouraging childbirth over abortion. The government seeks to achieve this ancillary goal, however, not simply by providing incentives to childbirth but rather by perpetuating ignorance and denying women information about abortion as a safe, legal alternative to childbirth. In effect, the regulations' purported purpose of promoting childbirth is a pretext

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49. Similarly the Court applies strict scrutiny to other violations of free speech, including discrimination on the basis of viewpoint, *FCC v. League of Women Voters*, 468 U.S. 364, 383-84 (1984), and conditioning federal funding on the relinquishment of first amendment rights to free expression, *Perry v. Sindermann*, 408 U.S. 593, 597 (1972); *Sherbert v. Verner*, 374 U.S. 398, 406 (1963).

50. In enacting Title X, Congress intended to establish a program that would provide the poor with comprehensive reproductive health care. During the floor debate in the House, then-Representative George Bush stated, "[m]ost important is that this legislation be recognized . . . as a health care service mechanism . . . " 116 Cong. Rec. H37370 (daily ed. Nov. 16, 1970) (statement of Rep. Bush). The statutory mandate of Title X is expansive:

> to assist in the establishment and operation of voluntary family planning projects which shall offer a broad range of acceptable and effective family planning methods and services (including natural family planning methods, infertility services, and services for adolescents).

42 U.S.C. § 300(a) (1982). For a complete discussion of the purpose of Title X, see Brief of Petitioner State of New York, *et al.* and Brief of *Amici Curiae* NAACP Legal Defense and Educational Fund, Inc., *et al.*

for the actual purpose of the regulations[51]—direct interference in the fundamental privacy and first amendment rights of women to make fully informed decisions between abortion and childbirth.[52]

Second, the government's means of banning abortion counseling and mandating referral to prenatal care are not narrowly tailored to serve the goal of encouraging childbirth without impermissibly violating the free speech and privacy rights of women served by Title X programs. The regulations clearly conflict with medical ethics that demand unrestricted communication between a physician and her patient.[53] The government's asserted interest here does not justify the enactment of health regulations that "depart from accepted medical practice," *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. at 431 & 454 (O'Connor, J., dissenting). Rather than being narrowly tailored to encourage childbirth over abortion, the regulations distort the physician-patient dialogue in a way that fundamentally impedes the patient's receipt of viewpoint neutral information and her autonomy in reproductive decision making.

Finally, the Title X regulations also fail to pass muster under the Court's most lenient standard of review, the rational basis standard. As the Court recently reiterated in *Hodgson*, under any analysis, an abortion regulation "cannot be sustained if the obstacles it imposes are not reasonably related to legitimate state interests." *Hodgson v. Minnesota*, 58 U.S.L.W. at 4962 (cita-

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51. At least one member of this Court has advocated searching scrutiny of the government's stated purposes as well as the means to achieve those purposes. In *Mississippi University For Women v. Hogan*, Justice O'Connor emphasized that "the mere recitation of a benign . . . purpose is not an automatic shield which protects against any inquiry into the actual purposes underlying a statutory scheme." 458 U.S. 718, 728 (1982) (quoting *Weinberger v. Wiesenfeld*, 420 U.S. 636, 648 (1975)).

Similarly, in a first amendment context, Justice O'Connor also suggested that strict scrutiny applies whenever burdens on speech are imposed on the pretext of furthering some general legislative interest: "[i]f . . . a city were to use a nuisance statute as a pretext for closing down a bookstore because it sold indecent books . . . the case would clearly implicate first amendment concerns and require analysis under the appropriate first amendment standard of review." *Arcara v. Cloud Books, Inc.*, 478 U.S. 697, 708 (1986) (O'Connor, J., concurring).

Justice O'Connor recently observed that the requirement of narrowly tailored regulation is "designed to 'ensur[e] that the means chosen fit' [the] compelling goal so closely that there is little or no possibility that the motive" for a regulatory scheme is illegitimate or unconstitutional. *Metro Broadcasting, Inc. v. FCC*, 58 U.S.L.W. 5053, 5072 (U.S. June 27, 1990) (O'Connor, J., dissenting) (quoting *Croson*, 109 S. Ct. at 493).

52. As this Court pointed out in *Hodgson*, "[a] State's value judgment favoring childbirth over abortion may provide adequate support for decisions involving [the] allocation of public funds, but not for simply substituting a state decision for an individual decision that a woman has a right to make for herself. Otherwise the interest in liberty protected by the due process clause would be a nullity." *Hodgson v. Minnesota*, 58 U.S.L.W. 4957, 4962 (U.S. June 25, 1990).

53. For a complete discussion of this point, see Brief of *Amici Curiae* of the American College of Obstetricians and Gynecologists, *et al.*

tions omitted). Because the effect of the regulations' ban on abortion counseling and referral is seriously to endanger maternal health, the regulations' goal of promoting childbirth actually undercuts Title X's overarching public health purpose in a manner that violates medically accepted practice. Any regulation which so clearly departs from commonly accepted medical ethics and practice cannot be rationally related to a legitimate state interest in promoting health and cannot be saved simply because it serves some ancillary purpose.

By analogy, suppose perceiving a serious threat of overpopulation, the government opted to respond to the crisis by limiting population growth through a program of male sterilization. A federal program of forced sterilization of men would violate a man's right to decide whether or not to have children, and would necessarily be struck down by the Court on privacy and equal protection grounds. *Cf. Griswold v. Connecticut*, 381 U.S. 479 (1965); *Skinner v. Oklahoma*, 316 U.S. 535 (1942). However, a government program providing federal funding of the full cost of male sterilizations (but not funding male fertility treatment) and establishing population control clinics for the performance of sterilization on demand would be a possible alternative under prevailing constitutional doctrine. *Cf. Maher v. Roe*, 432 U.S. 464 (1977); *Harris v. McRae*, 448 U.S. 297 (1980). Hypothesize further that an illness breaks out which causes sterility in men only, but can be cured if diagnosed and treated promptly. To further promote population control, the government enacts regulations which prohibit health care professionals in federally funded facilities from counseling men with the illness about its treatment. In this hypothetical, the legitimate goal of promoting population control is pursued by a means which violates an individual's fundamental rights and is a pretext for the unconstitutional purpose of denying men their right to choose whether or not to have children.

## CONCLUSION

*Amici* respectfully urge that the regulations should be invalidated as an impermissible "effort to deter a woman from making a decision that, with her physician, is hers to make." *Massachusetts v. Secretary of Health and Human Services*, 899 F.2d 53, 56 (1st Cir. 1990) (en banc) (quoting *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 759 (1986)). For all the foregoing reasons, the Court should strike down the Title X regulations as unconstitutional.

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